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GENERAL ASSEMBLY

PERMANENT COMMISSION ON
THE STATUS OF WOMEN

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Testimony of
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Before the
Public Health Committee
Monday, March 28, 2005

Re:
R.B. 1353, An Act Expanding the Availability of Health Insurance
R.B. 1333, An Act Concerning Medical Malpractice Reform

Good afternoon Sen. Murphy, Rep. Sayers and members of the Committee. My name is Leslie Gabel-Brett and I am the Executive Director of the Permanent Commission on the Status of Women. Thank you for this opportunity to offer testimony on two important issues before you today: R.B. 1353, An Act Expanding the Availability of Health Insurance and R.B. 1333, An Act Concerning Medical Malpractice Reform.

R.B. 1353, An Act Expanding the Availability of Health Insurance

As you may know, the PCSW convenes and co-chairs the Connecticut Women's Health Campaign and we have identified women's access to affordable health care as a high priority for our work. We strongly support the goals and vision underlying R.B. 1353 – to provide affordable health insurance to every person in our state. When people cannot afford health insurance, it is not only bad for their health – it is also bad for our economy. People without health insurance delay seeking medical care and are 25% more likely to die prematurely. They also tend to overburden hospital emergency rooms and shift the burden of uncompensated care to all of us.[1] In fact, the Center for Economic Analysis at UCONN estimates that uninsured residents of Connecticut received approximately $377 million in uncompensated care in 2002, and that our state loses

[1] Connecticut Health Policy Project, Policymaker Issue Brief #12, August, 2004

between $584 million to $1 billion each year due to the increased mortality and morbidity of people without health insurance.[2]

As much as 10% of our population, or 360,000 people, are uninsured. Employers provide a majority of health insurance coverage in Connecticut (64.8 percent, or approximately 1.9 million persons), *yet two thirds of uninsured adults are workers*. Medicaid covers only about 3.1 percent (about 94,000 persons.) Among those who are uninsured, nearly 30% have household incomes below $15,000 per year, and a total of 56% have household incomes below $25,000 per year.[3] About 44 percent of the uninsured have family incomes below 200 percent of the federal poverty level.

The question before all of us is: How shall we provide access to good health care and how can we pay for it? It is the position of the PCSW and many others that adults and children in our state in households with incomes up to 185% of the federal poverty level should be eligible for health care insurance through HUSKY A (which is Medicaid). As you know, Medicaid is reimbursed at the rate of at least 50% by the federal government. Federal Medicaid rules require comprehensive, preventive health care coverage that keeps people healthy; increases their employability; and saves the extra costs we all pay when uninsured people need health care for more serious medical needs. Moreover, providing health insurance for the entire family under the same eligibility rules increases the number of children who receive health care.[4] For these low-wage working families in which the adults are often dependent on multiple part-time jobs or change jobs frequently, we believe HUSKY A coverage is the most stable, cost-effective family health insurance program.

Therefore, we support the bill before you, but respectfully recommend that the threshold for eligibility (Section 1 (8)) for the state-operated health care plan be increased to 185% of the federal poverty level for adults and relative caretakers of children covered in HUSKY A if it can be coupled with legislation providing eligibility for HUSKY A to these adults. The threshold for adults without dependent children would remain at 100% of the federal poverty level, as currently stated in the raised bill.

Moreover, we recommend that the proposed bill require a sliding scale for premiums charged to eligible adults in the program created in Section 1, similar to the sliding scale based on a maximum of 5% of an enrollee's income, as proposed in Section 2. As you know, adults living in Connecticut with incomes between 100% and 200% of the federal poverty are extremely poor and barely able to meet basic expenses for housing and food.

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[2] Stan McMillen, Kathryn Parr, Moh Sharma, *Uninsured: The Costs and Consequences of Living Without Health Insurance in Connecticut*, Connecticut Center for Economic Analysis, University of Connecticut; Universal Health Care Foundation of Connecticut, December, 2004,.

[3] *Ibid*.

[4] Lisa Dubay and Genevieve Kenney, "Expanding Public Health Insurance for Parents: Effects on Children's Coverage under Medicaid, *Inquiry*, Vol. 38, October 2003, pp. 1283-1302

R.B. 1333, An Act Concerning Medical Malpractice Reform

As you may know, we have testified in the past on this topic for two reasons: First, because rapidly rising medical malpractice premiums have disproportionately affected obstetrician/gynecologists (OB/GYN's) who provide vital reproductive health care to women; and second, because caps on non-economic damages would disproportionately harm female patients who are victims of malpractice. The rapid rise in medical malpractice premiums is a serious women's health care issue that requires an effective solution.

We support most of the provisions of R.B. 1333 because it offers a balanced, comprehensive approach to reform. Its proposals include litigation reforms, stronger oversight and investigation of complaints against providers and new requirements for continuing medical education, incentives to increase patient safety, and prior rate approval for insurance premiums.

In addition to these reforms, we also urge you to consider government sponsored re-insurance or "no fault" compensation funds to help spread the risk and ensure that patients who have been injured and need expensive medical care can obtain it. One of the factors driving up the cost of insurance is the rising cost of health care itself. When an individual has a serious medical injury – whether it is caused by malpractice or not – the costs of the necessary health care may create an impossible burden for the individual and his or her family to bear. In some cases, a patient would choose a fair compensation plan administered by a government fund instead of rolling the dice and suing the health care provider. When no such fund or assistance is available, the tort system is often the only recourse available.

We oppose Section 13 that would require the commissioner of the Insurance Department to develop a proposal for caps on non-economic damages in three years if premiums have not decreased at least 15% by that time. While we understand that this is a compromise provision, we believe it is a self-defeating one. The insurance industry has a strong investment in the establishment of statutory caps on damages. They have the ability to raise and lower premiums as dictated by their business interests. Holding out the promise in statute that caps will be enacted after three years if premiums decrease will create a very strong business incentive to keep premiums high in order to trigger that provision.

I would like to explain why we oppose caps on non-economic damages. Empirical research conducted by law professor Lucinda Finley on gynecological malpractice cases over the past ten years in California and Florida shows that non-economic damages comprised approximately 75% of women's total awards. The reason is that the harm suffered by women in these cases include impaired fertility or sexual functioning, miscarriage, incontinence, and disfigurement of intimate areas of the body and these consequences, while very significant, are not directly related to economic losses. Finley concludes that capping non-economic damages will have a discriminatory impact on women patients that will be "the greatest when women experience the most profound sort of harm to their sexual and reproductive lives."

As you know, women earn approximately 25% less than men earn; limiting damages to primarily economic damages perpetuates this inequality in the face of injuries caused by malpractice. That is, the cashier gets little compared to the CEO even if the cashier has suffered the same or more serious injury. (This analysis applies, of course, regardless of the gender of the individuals – it is unfortunately true, however, that women are disproportionately represented in low-wage occupations compared to men.)

Women also have a longer life expectancy and are more likely to be old and poor. The tort system has two important purposes - on the one hand, to compensate victims of negligence or intentional harm and, on the other hand, to deter negligent or intentionally harmful behavior. For older, poor victims of malpractice with very modest streams of income, there would be little compensation and *no deterrence against malpractice* in their medical care because the economic risk is so low.

The medical malpractice system includes doctors, lawyers, hospitals, insurers and patients. It is clearly out of balance. But it does not make sense to begin our reform of this system by limiting funds to injured patients. We urge passage of R.B. 1333 and consideration of the additional measures we have recommended to reduce malpractice premiums. Thank you.